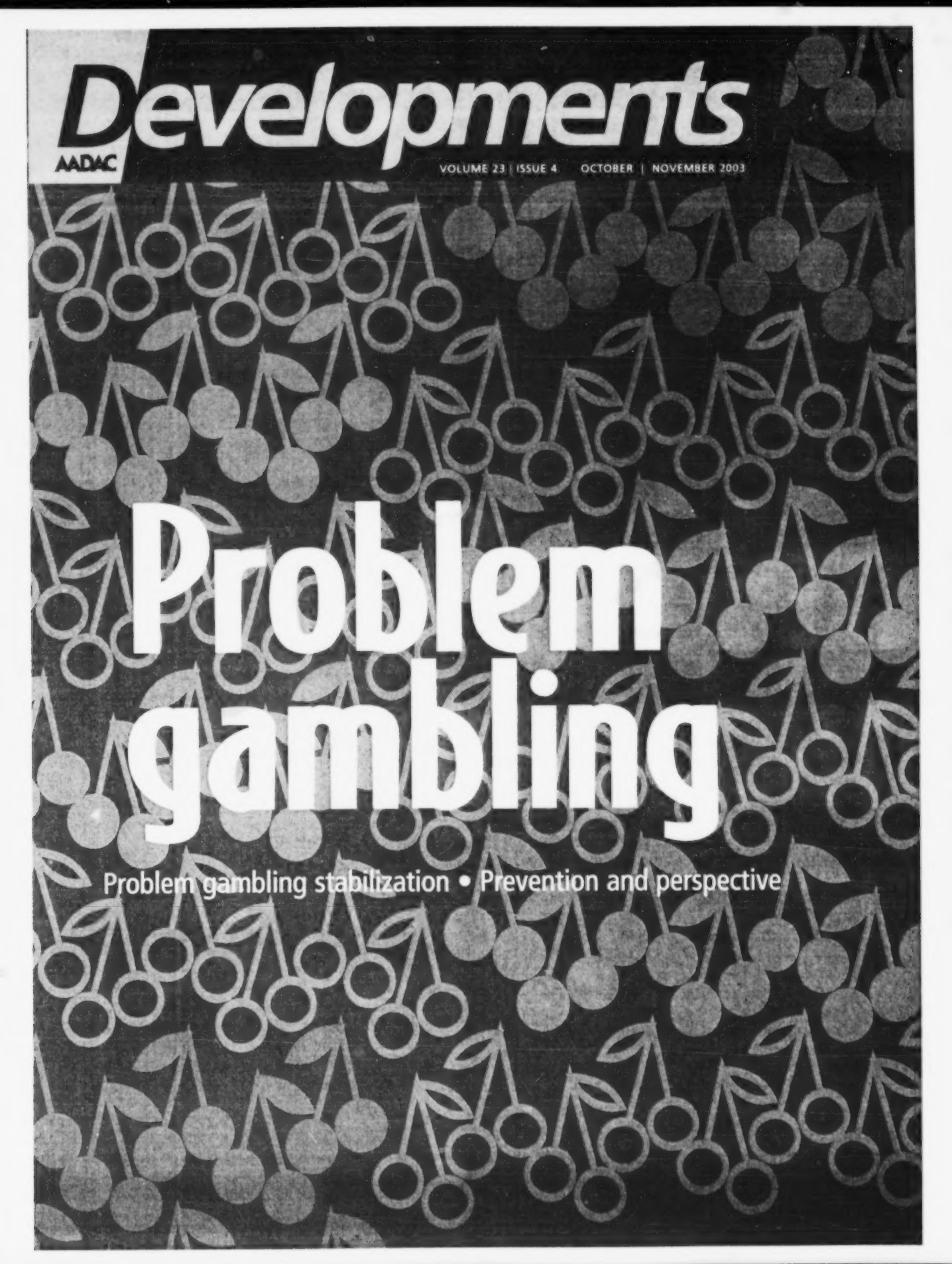




Developments

AADAC

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Problem gambling

Problem gambling stabilization • Prevention and perspective

In a sense, all addictions work is prevention. Even when a person already has an addiction, we work to prevent further harm to that person, whether by helping them to quit or by counteracting the damage associated with their addictive behaviour. The first two articles in this issue are about that kind of prevention. The third discusses prevention in the usual sense of the word, asking now that we know so much about prevention of problem gambling as an individual problem, are we doing enough as a society?

Problem gambling stabilization

The Henwood experience

By Gail Pesheau (Counselling Supervisor) and Judy Borais (Addictions Counsellor),
AADAC Henwood Treatment Centre

IN THE FIELD OF ADDICTIONS, we are very familiar with detoxification centres that offer a place for people to stay while their bodies get rid of the substances and heal from the physical neglect that often accompanies substance abuse. But where do you go when you have gambled intensely for the last several months, have scarcely slept or eaten, and have no plan for how to get out of your current gambling crisis?

Within a few years of AADAC receiving the mandate to prevent and treat problem gambling, several AADAC addiction counsellors and Gamblers Anonymous (GA) members together identified a need for residential treatment for those who had experienced a prolonged and devastating period of gambling. In 1998, a problem gambling crisis stabilization service was set up at the Walter A. "Slim" Thorpe Recovery Centre in Lloydminster, Alberta, a community of 19,000 people in east central Alberta.

In a review conducted after the first year of the stabilization program, Thorpe counsellors reported that clients came to the program with eating and sleep disorders, suicidal ideation, and anxiety and confusion about how to manage the situation in which they found themselves. The same review concluded that there was a need for additional service closer to larger urban centres. In 2000, AADAC's Internal Advisory Committee on Problem Gambling (IAC) consulted with AADAC staff, with crisis service providers, and with addiction service providers within and outside of Alberta. Based on this input and that of the Thorpe Centre staff, the IAC developed a program model for problem gambling stabilization.

In November 2001, the Problem Gambling Stabilization (PGS) pilot program was launched at AADAC's Henwood Treatment Centre, a 72-bed residential treatment facility in Edmonton. AADAC Research Services conducted a process evaluation for the first six months of the pilot.

The pilot program

The Problem Gambling Stabilization (PGS) Program was created to serve those who, after extensive gambling, find that they are unable to function without a safe environment that provides intensive counselling support and access to medical or psychiatric referral if necessary.

Clients who had problems with both gambling and substance abuse were eligible for admission, but they had to be free from the immediate effects of alcohol and other drugs at the time of admission and not in need of acute medical or psychiatric treatment.

Two client beds were allocated for the program, with voluntary admission for men and women, 24 hours a day. Clients could contact Henwood directly or through referral. AADAC outpatient sites, agencies funded by AADAC, other community agencies, and operators of AADAC's 24-hour Gambling Help Line were all invited to refer suitable clients to Henwood for stabilization. The final decision about admitting a given client rested with Henwood staff: nurses, counsellors and client care assistants.

Upon making contact with Henwood, clients were screened for their current gambling behaviour and level of distress. Current suicidal ideation, medical and psychiatric issues and substance use were also explored. Clients deemed to be inappropriate for the PGS Program were referred to other services (for example, detoxification centres, mental health services, hospitals, or health clinics). Clients appropriate for the PGS Program were cleared for admission immediately.

At intake, clients went through Henwood's standard admission and a nurse assessed their health. As clients were often exhausted, they were offered something to eat and encouraged to get some sleep. A thorough assessment was completed with clients, examining their functioning in major life areas and the role of gambling in their lives.

The client and a problem gambling counsellor then developed a treatment plan tailored to the client's needs. The treatment plan formed the basis of the stabilization component of the program. It included daily individual counselling, journaling, participation in therapeutic leisure activities, self-directed work on relevant topics such as guilt

and shame, stress management, financial management, a health consultation with the nurse as required and attendance at self-help (Gamblers Anonymous) meetings. Clients also had access to other forms of self-help, such as literature and audiovisual material.

Together, the counsellor and client worked on a plan for continued recovery after discharge, determining which treatment and other service options within and outside AADAC would be most helpful to the client.

For the six months that the PGS Program pilot was formally evaluated, 22 clients were admitted, staying an average of three and a half days. All clients agreed to participate in the process evaluation.

Of clients referred to the program, 50% were not admitted, either because they were not considered to be sufficiently distressed to require the level of service offered by the program, or because they needed emergency medical services, service beyond what could be provided by the program.

The counsellor's perspective

For those of us involved in the pilot, it was an exciting experience and one from which we learned a great deal. We were impressed by the clients' openness and willingness to look at the issues surrounding their gambling. Most had experienced a huge sense of isolation and secrecy as a result of their gambling. Once they started to talk, they found relief and a sense of being less burdened. Some came to recognize that solving their gambling problem would require additional intervention and support. Others, once stabilized, tended to underestimate the severity of their problem.

We found these clients to be functional individuals who were frequently surprised by the depth of chaos their addiction had brought to their lives. We were often amazed at the degree of movement made by clients in such a short time.

One of the challenges of the PGS Pilot Program was that it was offered in Henwood, which provides treatment for alcohol and drug addiction. We wondered how well problem gambling clients would fit in with the alcohol- and drug-dependent clients. While the problem gambling clients initially saw themselves as unique, their interactions with clients in the regular Henwood program gave them a much broader perspective. Several commented on the universal nature of addiction. One client said, "I thought my gambling problem was different from these people (those who drink or use drugs) but now I know that an addiction is an addiction." Another stated, "I can't believe that these drug addicts and alcoholics feel the same way I feel. They lost as much as I did."

The PGS Program continues to be offered at both Henwood and the Walter A. "Slim" Thorpe Recovery Centre. Henwood allocates two beds and a half-time addictions counsellor to the program. Access at both Henwood and Thorpe is available on a 24-hour basis and is only a telephone call away.

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Evaluating the Problem Gambling Stabilization Program

What did we learn?

An interview with Z'Anne Harvey-Jansen, M.Sc., senior researcher for the process evaluation of the Henwood Problem Gambling Stabilization pilot program

DEVELOPMENTS: *Did the program reach the intended people?*

ZHJ: Yes, it did. One in three clients arrived at the program at moderate or high risk of suicide. All the clients admitted were in psychological distress as measured by the Brief Symptom Inventory (BSI)^{*} and were probable pathological gamblers as measured by the South Oaks Gambling Screen. Their in-person interviews upon arrival also confirmed the severity of their psychological distress and gambling concerns. One client spoke of being just fed up and deciding to either drive his vehicle to the PGS program or into another vehicle and thankfully he chose the program. Another talked of feeling lost, avoiding everybody because she could not even stand being with herself.

DEVELOPMENTS: *What types of gambling were clients most concerned about?*

ZHJ: On arrival, most clients were concerned about their playing of video lottery terminals (82%), betting in casinos (73%), and playing of slot machines (73%).

DEVELOPMENTS: *Were there any surprises among the clients in crisis?*

ZHJ: We had anticipated that clients would be in need of a safe and quiet place and professional assistance to recover from both physical and emotional distress, but few clients reported a high level of physical health concerns upon arrival. However, when they looked back on their arrival, either towards the end of their stay or in the week following discharge, many realized that they really had been experiencing physical problems, but were focusing on the emotional ones instead. So we concluded that we need to continue to emphasize physical care and assistance. It was also interesting to note that PGS clients were more likely to be employed full-time or self-employed than would be true of the overall AADAC treatment client population (68% versus 50%).

DEVELOPMENTS: *Did the program help clients?*

ZHJ: Yes, the program helped the clients move beyond their crisis point, as the program had hoped to do. By the end of their stay, all clients had significantly lower overall psychological distress as measured by the BSI. The main

purpose of the PGS program is like the main purpose of detoxification for clients with substance abuse problems, that is, to get clients through their current crisis.

The program fills one place in AADAC's continuum of services for problem gamblers, and is aimed at a specific, small group of clients that may or may not be ready for actual treatment but are experiencing a serious gambling crisis. Almost all of the clients who were experiencing physical and emotional distress returned to gambling, but the program did not primarily aim to get them to stop gambling. During a crisis, treatment has to focus more on the acute symptoms than long-term change.

Some of those that have not returned to gambling said that family relations have improved because of better communication and greater honesty about gambling. Many of the clients say they now realize that they do not have to be alone: they are more comfortable with talking to family and friends or making use of resources at AADAC. The majority of the clients say that they are sleeping better and eating more consistently. They say the structured environment at Henwood gave them a chance to establish a more regular routine, and the workshops and counselling taught them about the importance of taking care of their physical health.

DEVELOPMENTS: *How did you collect information?*

ZHJ: We collected information from the PGS clients, referral agents, and staff, using a variety of methods: in-depth open-ended interviews, psychometric instruments administered upon the arrival and departure of clients, comparative document analysis and case note analysis.

DEVELOPMENTS: *Were any changes made to the program as a result of your evaluation?*

ZHJ: Clients requested more gambling-related material be included in the workshops, and that has happened. Henwood has added one more staff member on the weekends, so that the counselling staff on the weekend have more time for the PGS clients. As well, now that the program is no longer a pilot, PGS staff plan to advertise the program to a broader range of referral agents in Alberta.

DEVELOPMENTS: *Where can readers find out more about the method and results of the process evaluation?*

ZHJ: Program planners and researchers interested in understanding the evaluation in greater depth can contact Research Services at 780-427-0116 about the final report, "A Process Evaluation of Henwood's Problem Gambling Stabilization Program" (Harvey-Jansen, Z., George, S., Schmitt-Boshnick, M., Mitchell, J., and Andres, B. July 2003).

^{*}Derogatis, L. R. (1993) BSI: Brief Symptom Inventory Administration, Scoring and Procedures Manual.

Another perspective on prevention

By Theresa Hermans, Community Programs Consultant, AADAC Youth Services

As other presenters revealed during the conference, protection of the vulnerable is widely discussed in Europe.

A YEAR AGO, AADAC STAFF produced a list of guidelines for "best practice" in prevention. The guidelines were based on both AADAC's experience and prior work by Canada's Drug Strategy, a division of Health Canada. Most AADAC prevention workers know the checklist by heart. Good prevention is community-based. It emphasizes young people's strengths. It acknowledges individual and cultural perceptions of addictive substances and activities. It addresses protective and risk factors, working to enhance factors that reduce susceptibility to harmful behaviour and minimize factors that increase such susceptibility. It considers the stage of psychosocial development of the individual, and combines knowledge and interactive group process. And so on.

This was the training and the attitude that I took with me in May of this year to the 12th International Conference on Gambling and Risk-Taking.¹ As an AADAC youth problem gambling prevention worker, I hoped that the broad reach of the conference would give me some ideas that I could use specifically in the pursuit of the elusive "perfect prevention program."

Delegates and speakers had traveled from the United Kingdom (UK), Sweden, Norway, Australia, New Zealand, South Africa, Brazil, Italy, Indonesia, and Jamaica, and represented a range of backgrounds, from the gaming industry and government lottery organizations to public health officials and problem gambling researchers. Research presented at the conference reaffirmed AADAC's practices and approach to prevention. But there were also presentations that made me question whether that approach went far enough.

Paul Bellringer, chief executive of Gamcare, a national organization focusing on the social impact of problem gambling in the UK, brought a new dimension to my thinking on prevention. He spoke of recent liberalizing of the laws on gaming in that country, and the three principles that guided the general deregulation. The principles were 1) that gambling should be crime-free, honest and conducted in accordance with regulation; 2) that players should know what to expect and be confident that they will get it and not be exploited; and 3) that there should be adequate protection for children and vulnerable persons.

The third principle intrigued me. As other presenters revealed during the conference, protection of the vulnerable is widely discussed in Europe. When the focus is on adults,

we prevent problem gambling by teaching limit setting, dispelling false beliefs in the role skill plays in gambling, and explaining the actual odds of winning. But is this enough for prevention in youth? It occurred to me that our current choice of health promotion techniques that focus on the individual and not the problem is influenced by the individualistic nature of North American culture.

We currently have a generation of Alberta youth growing up with legal gambling as a common leisure activity for adults. These young people saw bingo used to raise funds for elementary schools and have seen greater access to gambling through vehicles such as the Internet. Keeping in mind that youth do not have the experience and often do not have the critical thinking that most adults have, how do we protect them from subtle encouragement to gamble, encouragement that comes as much from the normalization and increased presence of gambling as it does from actual commercial advertisement? To what extent is accessibility a risk? Do other activities embraced by youth culture, for example the Internet or video games, set the stage for future gambling problems? Is our culture's acceptance of get-rich-quick and instant gratification solutions shaping the struggles of future gamblers? It is possible that strength- and skill-based prevention activities will not be enough to significantly address the complications ahead.

For me, the conference has provided more questions than answers, but I find those questions important. We need to find answers that go beyond our cultural assumptions, and we need these answers to be based on sound research. Knowing what works for the individual is a good start, and AADAC's best practice guidelines serve an important purpose, but another question awaits us, one of social responsibility: what will work for us as a society, and beyond that, what are the global solutions to prevention of gambling problems? The perfect prevention program will always be elusive. What is important is that we always remain willing to pursue it.

¹Held May 27 to 30, 2003 in Vancouver, British Columbia, the conference was sponsored by the Institute for the Study of Gambling and Commercial Gaming (University of Nevada, Reno).



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Making a difference in people's lives by assisting Albertans to achieve freedom from the harmful effects of alcohol, other drugs and gambling

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We value individuals, families and communities as partners in addressing addiction problems.

We value staff and their knowledge, skills, creativity, initiative, and expertise.

We value service delivery that is grounded in research and experience.

THE PURPOSE OF DEVELOPMENTS

To enhance allied professionals' knowledge and understanding of addictions issues.

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This comprehensive program is designed to be flexible, effective, and easy to use. It provides the addiction professional with a complete, up-to-date program for the treatment of problem gamblers. The program includes 16 modules that address topics such as gambling as a life style, debt management, and leisure planning. Modules are designed for use either individually or in sequence, and are suitable for either residential or non-residential treatment. Each module includes background information, overheads and client activities.

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Explore the topic of youth gambling with teens to help them learn about the risks, odds, and consequences of betting using the activities in this easy-to-use and informative workbook. Limited quantities are available free to Albertans through your local AADAC office; in greater quantities or outside Alberta, the workbook is priced at \$60 plus GST, shipping and handling (ordering information below).

Parent Information Series

This colourful and creative 20-part information series will be of interest to parents of children of all ages and to anyone who is a key influencer in a child's life. The series begins with a collection of tip sheets for parenting very young children called "Create It," progresses through childhood developmental phases with "Nurture It" and "Choose It" tip sheets, and ends with advice for parents who need help when youth are harmfully involved with alcohol, other drugs, or gambling in the "Get It Back" series.

These sheets can be printed from the AADAC Web site (www.aadac.com) by following the link for Parents and Teachers. In print, the tip sheets are available free to Albertans in limited quantities through your local AADAC office. For larger quantities or for those ordering from outside Alberta, the tip sheets are priced at \$50 a package for 50 of any one title, a complete set of all 20 tip sheets is \$40. GST, shipping and handling will be added.

TO ORDER: AADAC resources are available through your local AADAC office. Outside Alberta, order from AADAC Resource Development, #200, 10909 Jasper Avenue, Edmonton, AB, Canada, T5J 3M9, TOLL-FREE 1.800.280.9616, FAX 780.422.5237; E-MAIL: rdm@aadac.gov.ab.ca

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